MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 10, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, February 10, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Doug Berger, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory members Representative Van Braxton and Representative William Brisson were present. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She announced that for those listening over the internet, that handouts from the meeting were available on the LOC website. Representative Insko asked for a motion to approve the minutes from the January 13, 2010 meeting. The motion was made by Representative Braxton and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS) provided a brief update. Items of interest included:

- DHHS is examining ways to obtain greater input, ideas, and information from consumers. An example was to better utilize and strengthen the State Consumer Family Advocacy Council (SCFAC) which would provide better communication across the State.
- DHHS is finalizing the process of separating the accreditation and certification of Central Regional Hospital (CRH) and Dix Hospital. They were originally recognized as one hospital on two separate campuses. This change which will prevent future liability issues in one facility from affecting the other facility. Lack of adequate funding has created staffing difficulties at both hospitals. Recurring money is needed to hire permanent staff. The transfer of patients from Dix Hospital to CRH will hopefully take place within the next few months. The operation of all the facilities is costing approximately $30M a year more than budgeted. Actions are being taken to address the deficit at the State facilities.
- Murdoch Center is converting 6 beds into a short-term unit for emergencies for children until a better long-term solution can be provided.

- Personal Care Service – new system tracking services should be in place by March 1. It was determined that some consumers should not be receiving PCS services or were receiving too many of these services. Once letters go to consumers eliminating or reducing services, consumers can appeal the decision. Services will continue until a final decision is made on an appeal.

Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, gave an update on utilization of, and expenditures for: CS services, Targeted Case Management, CS Team, and Intensive In-Home Services. (See Attachment No. 2) She explained that the graphs on the left showed updates of expenditures of selected services requested by Committee members. On the left side, the graph indicates the actual number of people served. Ms. Larson was asked to group the child services and adult services together in the future.

Rose Burnette, Developmental Disabilities Project Manager for DMH/DD/SAS, addressed plans for development and implementation of the CAP-MR/DD Tiered waivers. (See Attachments No. 3A and 3B) Ms. Burnette explained the minor revisions to the Supports Waiver, the division of the Comprehensive Waiver into two separate Bands, and the new waiver – the Community Intensive Waiver. Her presentation included the following points of interest:

- The current Tier 1 waiver has 130 slots. The General Assembly appropriated $4M for Tier 1 slots allocating an additional 1,000 slots. DHHS created a standardized methodology to equalize the allocation of those slots. Using that formula gives each LME slots for their catchment area.
- Funding for the new Tier 3 waiver will come from funds in the current allocation.
- The goal is to more clearly define each waiver specific to the individual's needs; tailoring the services to meet those needs, thus creating more cost effectiveness and enabling more individuals to be served.

Leza Wainwright, Director for DMH/DD/SAS, addressed the status of the establishment of the DD Waiting list. (See Attachment No. 4) Ms. Wainwright reviewed the criteria established in legislation and information and statistics from other states with waiting lists. She explained that a standardized prioritization tool has been developed and is being used within the 2 tiers of the CAP MR/DD waiver. The tool takes into consideration the severity of need and the time an individual has been waiting for services. Ms. Wainwright reviewed the responsibilities of a stakeholders workgroup charged with designing a short term and long term solution to the mandate. The outcome of the short term solution will be in place within 30 days.

Dr. Craigan Gray, Director, Division of Medical Assistance, focused on questions from Committee members over the last few meetings regarding the demographics of recipients and providers participating in the Medicaid program. He noted:

- Since July, 2009, over 2.5 million people have been served by the Medicaid program. There is frequent transition in and out of the program. Average daily census is about 1.6 million.

- 39.7% of the Medicaid population is white, non Hispanic; 37.4% is African-American, non Hispanic; 9.1% is Hispanic; and; 13.6%, all others.
- Medicaid providers number 63,244 which only includes those processed through the Medicaid program. Of that number, 27,236 are physicians, 25,976 are ancillary providers, and 10,032 are non-licensed providers. The ethnic diversity of providers is not tracked.

After lunch, Dr. Michael Lancaster, Chief of Clinical Policy, DMH/DD/SAS, reported on the new legislative measures enacted in the last Legislative session (H.B. 1189 and H.B. 243) and on progress made in Mobile Crisis Services. (See Attachment No. 5) Items of interest included:

- H.B. 1189 - Outpatient commitment process information generated in the emergency department (ED) must be communicated to the LME prior to the consumer's discharge.
- Grant funding will allow the East Carolina University Department of Psychiatry to employ 3 psychiatrists to work through telepsychiatry with EDs throughout the east to provide psychiatry to underserved EDs.
- North Carolina is viewed as a leader in telepsychiatry with more billings and providing more services than other states in the country.
- DHHS wants ED's to establish a single number in their area to call for telepsychiatry services, perhaps through the LME Screening and Triage Referral line.
- H.B. 243 - Amends the law governing the affidavit and petition process for involuntary commitment where the affiant is a physician to provide that if inpatient commitment is recommended, but no 24-hour facility is available, the respondent may be detained temporarily at the site of first examination under appropriate supervision for up to seven days. If after seven days a 24-hour facility is still unavailable, then that fact is to be reported to the clerk of superior court and the commitment proceedings terminated. New commitment proceedings may be initiated, but the affidavits used in support of the earlier proceedings many not be used. New affidavits must be filed and, if the affiant is a physician, a new examination conducted.
- The act also amends the Session Laws creating the First Commitment Pilot Program and expands the pilot from 10 LMEs to up to 15 LMEs.

Regarding the Mobile Crisis Teams, (See Attachment No. 6), Dr. Lancaster reported that the General Assembly has funded 30 Teams across the State. Four years ago, this crisis service began as a pilot project with 10 Mobile Crisis Teams, 9 of which are still operational today. Several points of interest included:

- Some LMEs have more than 1 Mobile Crisis Team but virtually every county in the State is covered by a Mobile Crisis Team.
- Mobile Crisis Teams are available 24/7/365 and have expertise in MH/DD/SA. People should consider calling Mobile Crisis before going to an emergency room and the police should consider calling Mobile Crisis before taking someone to jail or an emergency room.
- 40-45% of services are in the ED setting.

- Mobile Crisis intervention early in crisis can prevent consumers from moving into a higher level of care.
- With the absence of a behavioral healthcare professional in the ED, the ED doctor is more likely to be more conservative in an assessment and admit the patient.

Christina Carter, Implementation Manager, DMH/DD/SAS, addressed the N.C. Systemic, Therapeutic, Assessment, Respite and Treatment Program (NC-START). (See Attachment No. 7) Points of interest included:

- North Carolina is the only state in the country to take the START model statewide.
- Part of collaboration is an automatic referral when someone is discharged from a developmental center to the NC-START Team.
- Data in graph covers information gathered from April, 2009 – September, 2009.

Luckey Welsh, Director of State Operated Healthcare Facilities, provided an update on the Alcohol and Drug Abuse Treatment Centers (ADATC). (See Attachment No. 8) He said that ADATCs provide the highest level of treatment for adults with substance abuse addictions and co-occurring mental health disorders that are so severe they cannot be served in the community. His presentation included the following points of interest:

- Overall admission to the ADATCs decreased in 2009 due to a number of beds closed at the Julian F. Keith center in preparation for other centers opening. The 2010 projection indicates that admissions will climb.
- Involuntary commitment admissions are rising in the Acute Crisis Units. Prior to the availability of ADATC Acute Care Units, these individuals would have been referred to the State psychiatric hospitals.
- Staffing difficulties exist due to budgetary restrictions and changes in the complexity of the population served at the ADATCs.
- ADATCs have contact with treatment facilities in the community since there is chance of a relapse. Sobriety may not be attained until after 6 or 7 treatments.

Mr. Welsh was asked to provide the number of community facilities there are across the State and their location.

There being no further business, the meeting adjourned at 2:25 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant